EXHIBIT F

- **Plaintiff Edward Peña's Consent for Elective Penile Enhancement Surgery, dated October 2, 2020**

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CONSENT FOR ELECTIVE PENILE ENHANCEMENT SURGERY

NOTE – NO SMOKING 30 DAYS BEFORE AND AFTER SURGERY

Notice to Patient

State law guarantees that you, the patient, have both the ***right*** **and** ***obligation*** to make decisions concerning your health care. While your physician can provide you with the necessary information and advice, only **you** can make the decision whether or not to proceed with any treatment. This form has been designed to acknowledge your informed acceptance of treatment recommended by your physician.

The information that follows is the text from the standardized Surgical Consent form. It is used for the most minor of procedures to the most complicated and serious ones. It is not meant to frighten you but rather to inform you that ALL procedures, including the procedure you are contemplating, carry some risks. For instance, many operations have only the remotest chance of needing blood transfusions, yet blood transfusions are mentioned in the form below. The purpose of this form is to help you better understand your upcoming operation. **If you don't understand anything, it is important and you are encouraged to ask your physician or a member of the health care team to explain it to you, so that you are fully informed**.

Patient's Consent

I hereby authorize Dr. James J. Elist, James J. Elist, M.D., a California Medical Corporation and/or agents, employees, partners and/or assistants selected by said physician to treat the following condition(s):

DESIRED PENILE ENHANCEMENT, PENILE WIDENING, AND ENHANCEMENT IN THE APPEARANCE OF PENILE LENGTH, SKIN EXPANSION ("CONDITIONS")

The procedures planned for the treatment of my condition(s) have been explained in detail to me by my physician and/or member of the medical team and are described as follows:

PLACEMENT OF SUBCUTANEOUS SILICONE BLOCK UNDER PENILE SKIN ("PROCEDURES")

I have (a) been advised by my physician, verbally and in writing of the possible risks and complications associated with the foregoing procedure(s), including, without limitation, the risks listed below (b) been advised not to consume any aspirin products for 14 days before and after the scheduled surgery, (c) been provided an opportunity to ask questions regarding the procedure(s) and the risk(s) and alternatives, including no surgery, and (c) have had all of my questions satisfactorily answered.

1. I hereby certify that I have not taken any medication(s) except those that may have been ordered by Dr. James Elist, am not under the influence of any medication(s) or illicit drugs, and that no medication has been administered by any healthcare provider, which may influence my decision to sign the consents contained herein. I further certify that I have been provided with an opportunity to review the consents and have any questions I may have concerning the same answered to my satisfaction.

Initials EAP

2. I certify that I speak, understand and read the English language fluently. I have been informed and understand that I have the right to an interpreter and have been offered an interpreter to interpret and explain the contents of this document before I signed it and I declined such offer as I am fully able to read and understand the contents hereof.

Initials EAP

POSSIBLE RISKS AND COMPLICATIONS OF WHICH I HAVE BEEN ADVISED, INCLUDE, BUT ARE NOT LIMITED TO:

POSSIBLE RISKS AND COMPLICATIONS	**PATIENT INITIALS**
INFECTION OR EROSION OF SILICONE BLOCK REQUIRING REMOVAL	EAP
CONTINUED BENDING, INSTABILITY AND/OR WRINKLING OF PENIS AND/OR IMPLANT IN ERECT AND FLACCID STATES	EAP
PATIENT OR PARTNER DISSATISFACTION WITH RESULTS	EAP
EXTENDED PENILE OR SCROTAL PAIN AND DISCOMFORT	EAP
LACK OF SENSATION ON PARTS OF PENIS FROM NERVE INTERRUPTION CAUSING NUMBNESS AND LOSS OF SENSITIVITY	EAP
INFECTION OF INCISION REQUIRING FURTHER TREATMENT	EAP
MODERATE TO SEVERE SCAR TISSUE FORMATION, FIBROSIS AND/OR POSSIBLE DETACHMENT OF SUTURES	EAP
PENILE SHORTENING AND/OR POSSIBLE PENILE/IMPLANT MISALIGNMENT	EAP
CUTANEOUS HYPERSENSITIVITY REACTION, MODERATE FOREIGN BODY REACTION, POSSIBLE URETHRAL DAMAGE	EAP

TEMPORARY REACTIONS, SKIN NECROSIS REQUIRING SKIN GRAFT OR SECONDARY CLOSURE, SWELLING, ERYTHEMA AND/OR SHARP WRINKLES	EAP
LOCALIZED GRANULAMATOUS REACTIONS AND/OR SKIN PIGMENTATION	EAP
ABSCESS FORMATION AND/OR COLLECTION OF FLUID (SEROMA)	EAP
A COLLECTION OF BLOOD UNDER THE SKIN (HEMATOMA) AND/OR BLEEDING AND/OR TRANSIENT BLACK AND BLUE BRUISING (ECCHYMOSIS)	EAP
EXTENDED SEMI ERECTED NON-DROPPED PENIS AND/OR PENILE DEFORMITY	EAP
PENILE RETRACTION IN ERECT AND FLACCID STATES	EAP
POSSIBLE IMPOTENCE REQUIRING ADDITIONAL TREATMENT	EAP
POSSIBLE LOW URINARY TRACT DIFFICULTY AND/OR URINARY RETENTION	EAP
REMOVAL OF IMPLANT MAY RESULT IN PENILE RETRACTION, SCAR FORMATION, AND OTHER POTENTIAL COMPLICATIONS, NECESSITATING ADDITIONAL TREATMENT	EAP

I HAVE ALSO BEEN ADVISED THAT ALTERNATIVE THERAPY MAY INCLUDE OBSERVATION OR NOT UNDERGOING SURGERY

I recognize that, during the course of the operation, post-operative care, medical treatment, anesthesia or other procedures, unforeseen conditions may necessitate additional or different procedures than those set forth. **Therefore, by signing below and initialing this paragraph, I authorize my physician(s) named above, and their assistants or designees, to perform such surgical or other procedures, as are in their professional judgment, necessary and desirable.** The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment are known to my physician at the time the medical or surgical procedure is commenced.

Initials EAP

I have been informed that there are significant risks such as severe loss of blood, infection and cardiac arrest that can lead to death or permanent or partial disability, which may be attendant to the performance of any procedure. I realize that in those cases where an incision is needed, infection, incisional pain, or hernia formation (weakness or bulging) can occur and may require further treatments or procedures.

Initials EAP

I realize that the list of risks and complications on this form may not include all possible or known risks of the intended surgery but is limited to the more common or severe ones. I realize that new risks may exist or may be found in the future that are not mentioned on this consent form.

Initials EAP

I acknowledge that no warranty or guarantee has been made to me as the results of my procedure or cure of my condition.

Initials EAP

I have been offered independent pre-surgical psychological evaluation for this procedure, and respectfully decline undergoing such evaluation

Initials EAP

I consent to the administration of anesthesia by my attending physician, an anesthesiologist, or other qualified party under the direction of a physician as may be deemed necessary. I understand that all anesthetics involves risks and potential complications and possible serious damage to vital organs such as the brain, heart, lung, liver and kidney, and in some cases, may result in paralysis, cardiac arrest and/or brain death from both known and unknown causes.

Initials EAP

I consent to the use of transfusions of blood and blood products as may be deemed necessary by my physician. I understand that diseases can be transmitted via these blood products, including AIDS and hepatitis.

Initials EAP

I acknowledge that any tissues or parts removed surgically may be disposed of by the hospital, or surgery center, physician in accordance with accustomed practice.

Initials EAP

I acknowledge that allergic reaction(s) (previously unknown) to any medications used the pre-and post-operative treatment may occur.

Initials EAP

As part of the surgical procedure, a surgical drain is inserted. It is your responsibility as the patient to follow the detailed instructions which have been provided to you in writing regarding the surgical drain. Moreover, it is your responsibility to attend your final appointment after the procedure to have the surgical drain removed by the medical staff. If you decide not to attend to your final appointment, which is against medical advice, it is your responsibility to find and seek a medical professional who will remove the surgical drain, and you will be responsible for all costs associated with this surgical drain removal. The clinic will in no way accept any responsibility for any complications if you the patient decides not to follow the surgical drain instructions or if you decide to have the surgical drain removed by a medical professional not affiliated with the clinic. Moreover, it is possible that the surgical drain cannot be removed during the final visit. If this is the case, it is your responsibility as the patient to make alternative travel plans at your cost to allow for the surgical drain to be removed at a time that is medically required. Finally, while unlikely, there are potential risks and complications specifically associated with the surgical drain, including breakage of the drain, infection, pain, soreness, and other potential complications and risks. These risks and complications may require additional medical or surgical intervention.

Initials EAP

I acknowledge that I fully understand all of the contents of this consent form and that I have been encouraged and provided an opportunity to ask my physician(s) and/or their associates to explain any aspects of this consent form that I do not understand.

Initials EAP

I certify that my physician has fully informed me of the nature and character of the proposed treatment, of the anticipated results of the proposed treatment, of the possible alternative forms of treatment, including non-treatment; and the recognized serious possible risks, complications, and the anticipated benefits involved in the proposed treatment.

Initials EAP

Patients who have had any previous penile and/or genital surgeries/procedures, including, but not limited to, fat injection, suspensory ligament division, AlloDerm insertion, PMMA insertion, and others, are likely NOT candidates for the silicone implant insertion procedure. Patients must disclose in writing in advance to the medical clinic if they have pursued any previous penile and/or genital surgeries/procedures at any time. If a patient fails to make such a disclosure in writing to the medical clinic, the implant may not be inserted during the operation at the surgeon's sole and absolute discretion, and the patient will be responsible for any and all costs associated with the surgery.

Initials EAP

Any photograph shown to me were used only to illustrate the benefits which might be expected from this type of surgery and no promises or guarantees were made as to specific or similar results. Permission is given of photographs, which may be used for scientific purposes.

Initials EAP

I agree to abide by all post-operative, rehabilitation instructions, which have all been explained to me in detail both in writing and verbally. I understand that some patients have to be in a convalescent status with a generous amount of bed rest for the first week after surgery and that for one month after surgery. I will not engage in any stressful physical activity including excessive bending, lifting, or participation in any sports. I will abstain from all sexual activity, including masturbation, oral sex, anal sex, and vaginal penetration, until cleared by the physician. I also agree not to manipulate my penis, engage in any rigorous activity, or induce erections (even to take post-operative photos for the clinic) unless instructed by the physician. I will not use any medications, lotions, creams, etc, particularly in the genital area, unless instructed by the physician and/or his associates. I also understand that recovery is highly individual and may vary significantly in any particular case. I understand that full rehabilitation can take considerable time, including months, if not years. Any deviation from the post-operative instructions will likely result in additional complications and risks, which may require additional treatment, including potentially surgery.

Initials EAP

Consistent and engaged post-op care is essential. For example, cigarette smoking, excessive alcohol consumption, and any sexual activity prior to clearance may damage the implant and may cause infections and other complications.

Initials EAP

Patient acknowledges that frequent masturbation and/or other types of traumatic sexual activity and/or a history of frequent masturbation and/or other types of traumatic sexual activity may cause micro trauma, micro bleeding, adhesion, and/or scar tissue formation in the penis, which may cause retraction of the penis among other potential outcomes.

Initials EAP

We have observed that certain groups of patients are predisposed to scar tissue formation (e.g., African-American patients) that can damage the patient's skin. As a result, in this group of patients, there is a higher risk for penile curvature, shortening, and other deformities due to scar tissue formation. I understand that I may be predisposed to scar tissue formation. Scar tissue formation may require additional treatment, including, but not limited to surgery, which has its own risks and complications.

Initials EAP

Changes, if any, in the appearance of the erect length of your penis are unpredictable and depend on the patient's anatomy and physiology. This does not constitute a warranty or guarantee of the results of the procedure.

Initials EAP

We have observed that a medium or large-sized supra-pubic fat pad can interfere with the stretching and elongation process of the penis by applying pressure and weight on the base of the penis and the implant, particularly in an upright position. I acknowledge that the pressure and weight caused by the fat pad may retract or pull the penis inside, in opposition to the implant, and may damage the implant. To achieve the best possible result after the penile implant procedure, the clinic highly recommends that you reduce the size of the fat pad as much as possible through regular exercise, healthful eating habits, and other actions under the supervision of specialists and only after you have been cleared to exercise by the medical staff.

Initials EAP

The final size of the implant will be determined intra-operatively by Dr. Elist in consideration to the patient's anatomy, safety, and appearance as well as chance of successful recovery. Dr. Elist will take into consideration the patient's desires and wishes however will uphold above all else the patient's safety, health and aesthetics. I also understand that a layer of soft mesh will be added to the distal tip of the implant during the procedure. I understand the potential risks, complications, and benefits of the use of this soft mesh.

Initials EAP

I hereby certify that I will consult exclusively with Dr. Elist's office on any follow-up consultations, questions, communications, procedures, and/or comments. Should I consult with or conduct any related procedures with any other professionals, Dr. Elist's office will not be held responsible or liable for any adverse events (physical or psychological) that may result.

Initials EAP

I agree to withhold from manipulating my penis for 6 weeks or more to allow for the implant to incorporate into my body and for the sutures to bind securely to the underlying tissues. Manipulation can result in dehiscence of the sutures and sharpening of the edges. Should a manipulation result in these conditions, any subsequent repairs by Dr. Elist's office will be at patient's cost.

Initials EAP

I give my permission for all matters and information related to my patient file and procedure, including but not limited to genital photography before, during and after procedure and observation of my procedure by anyone at the sole and absolute discretion of Dr. James Elist, and agree that these photographs and patient information and materials shall be the property of Dr. James Elist, and may be utilized for, but not limited to publication in scientific journals, clinical investigations and research, or presented for scientific reasons or in a manner directly related to the practice of medicine, research, and approval/clearance processes with relevant regulatory authorities. Any patient information will be de-identified.

Initials EAP

I have discussed this procedure with my sexual partner or "significant other" (if I have one) and have gained their approval, or after careful consideration of my situation and relationship, have decided to proceed. I am aware that there will be a period of sexual abstinence and can appreciate the emotional consequences of this hiatus, as well as any unanticipated complications stemming from this procedure. I have not been treated by a psychologist, psychiatrist, or physician for any emotional disorder, nor do I believe I have any significant emotional disorder presently.

Initials EAP

I have been informed that after reviewing the information contained in this form, I have the right to cancel any scheduled procedure(s). I understand that I will be refunded my deposit and/or full amount minus a $1,000 administrative fee if cancelled more than one week from the surgery date. If cancelled less than 7 days from the surgery date, a $1,500 administrative fee will be deducted from the refunded amount. I understand that if I do not show up for the procedure without any prior notice, I will be assessed an additional $1,000 fee. Given the fixed costs associated with the procedure, unfortunately we cannot honor any refunds under any circumstances whatsoever after the surgery has been performed.

Initials EAP

My decision to have this operation is not made in ignorance of the risks of surgery.

Initials EAP

Any questions, comments, issues, support, complications, dissatisfaction due to unrealistic expectations or follow-up surgery deemed medically necessary by Dr. Elist or voluntarily desired against Dr. Elist's advice in the future, must solely be taken care of and addressed by Dr. Elist and his staff. I also acknowledge that currently, very few physicians beyond Dr. Elist have extensive knowledge on the implant procedure and the required post-operative steps. Therefore, I understand that I am encouraged to maintain contact exclusively with Dr. Elist's clinic for any questions, comments, concerns, etc. that I may have on the procedure. I understand that the clinic highly discourages seeking information elsewhere as the information provided can be false, misleading, and inaccurate. I am encouraged to pursue any and all subsequent treatments related to this implant procedure with Dr. Elist's clinic. Otherwise, James Elist, M.D. nor James J. Elist M.D. Inc. will not accept any liability or responsibility for physical or mental permanent damages incurred to the patient.

Initials EAP

I have been informed by Dr. Elist and understand that the time frame of healing, recovery, outcome and penile size gains may vary from person to person. It may take 1 year or longer from the date of the surgery for gains in penile size to begin to develop. Attempting to rush or alter the outcome by using methods or devices not approved by Dr. Elist and/or his staff, can result in adverse reactions and consequences, which Dr. Elist may not be held liable for.

Initials EAP

By signing below, I agree to keep in the strictest confidence and not to disclose, under any circumstances, all aspects my relationship with Dr. James J. Elist, James J. Elist, M.D., a California Medical Corporation and/or all of their past, present professional corporations, partnerships, agents, servants, employees, partners, directors, shareholders, assistants or physicians selected by them and all other persons (collectively, the "Elist Parties"), including, without limitation, relating to the CONDITIONS, PROCEDURES AND THE EFFECTS thereof. I further agree that in the event I breach this confidentiality provision, the Elist Parties shall have the right to injunctive relief, in addition to the other remedies available to them, to enforce such provision.

Initials EAP

I certify that I have been given the option and opportunity to take a copy of this eight (8) page form for further review at my leisure before signing it, that it has been explained to me and that I have read it or have had it read to me and that I understand its contents.

Initials EAP

Patient or Guardian Signature EAP Date 10/2/20 Time 9:50

Name (print) Edward Peña Witness

State of California
County of Los Angeles

On _____, before me, _____, Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

Witness my hand and official seal.

_____
NOTARY PUBLIC

I have explained the medial procedure or surgery stated on this form (page 1), including the possible risks, complications, alternative treatments (including non-treatment and anticipated results) to the patient and/or his/her representative before the patient or his/her representative signed this consent form.

Physician's Signature _____ Date 10-2-20